Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $17,875.75 for dates of service 03/19/01 through 05/15/01.

   b. The request was received on 03/14/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 02/20/02
   b. HCFA(s)
   c. TWCC 62 forms
   d. Reimbursement data
   e. Medical Records
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution dated 05/16/02
   b. TWCC 62 form
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 05/09/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 05/10/02. The response from the insurance carrier was received in the Division on 05/17/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor:

   "The relevant issue involves (Carrier's) contention that the amount they reimbursed (Provider) for the services provided is reasonable. (Provider) billed at a rate of $150.00 per hour for multidisciplinary, chronic pain management services. (Carrier) reimbursed (Provider) at a rate of $74.00 per hour. It is (Provider's) assertion that the amount

reimbursed is not reasonable, and in fact, is considerably less than the standard level of reimbursement established in the State of Texas for such services."

2. Respondent:

"EOBs do not demonstrate this carrier's methodology is not in compliance with Section 413.011 (d) of the Texas Labor Code or that this carrier is not in compliance with TWCC Rule 133.304 (i). EOBs do not prove the carrier's represented by the EOBs are in compliance with Section 413.011 (d) if the Texas Labor Code or that the carrier's are in compliance with TWCC Rule 133.304 (i)."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 05/14/01 extending through 06/19/01.

2. The carrier's EOB denial submitted is "M-THE REIMBURSEMENT FOR THE SERVICE RENDERED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON BILLING AND PAYMENT RESEARCH AND IS ACCORDANCE WITH LABOR CODE 413.011(B). "A-THE TREATMENT RENDERED EXCEEDS THE PREAUTHORIZED TREATMENT REQUESTED AND/OR APPROVED. F-REDUCED OR DENIED IN ACCORDANCE WITH TWCC MEDICAL FE GUIDELINE'S GROUND RULE(S)."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
03/19/01	97799-CP-AP	$1,050.00 (7.0 units)	$518.00	M	DOP	TWCC Act & Rules Sec. 413.011 (d), Rules 133.304 (i) & 133.305 (i) MFG;MGR (II)(C)(G) MFG GI (III)	The provider has included in their dispute packet, documentation (EOBs from other carriers) that indicates a higher rate of reimbursement. The issue is what is "fair and reasonable" reimbursement for the services rendered. The referenced GI states, "…(DOP) in the …(MAR) column indicates that the value of this service shall be determined by written documentation…" The provider is a non- CARF accredited facility. The provider billed in accordance with the referenced Rule and medical documentation indicates that the services were rendered. Regardless of the carrier's lack of methodology and response, the burden remains on the provider to show that the amount of reimbursement requested is fair and reasonable. In light of recent SOAH decisions, where providers have submitted EOBs for documenting fair and reasonable reimbursements, SOAH has placed minimal value on EOBs for documenting fair and reasonable. The willingness of some carriers to reimburse at or near the billed amount is fair and reasonable and does not show how effective medical cost control is achieved, a criteria identified in Sec. 413.011 (d) of the Texas Labor Code. Therefore, additional reimbursement is not recommended. For the dates of service 04/17/01 denied "**A**", the pre-authorization letter dated 03/16/2001 indicates that the pre-authorization was given for dates of service 03/19/01-04/13/01. Therefore, the provider did not get pre-authorization and reimbursement is not recommended for DOS 04/17/01. For the date of service 04/03/01 denied "**F**", the provider billed in accordance with the referenced rule. Therefore, reimbursement is recommended in the amount of $75.00.
03/20/01		$1,237.50 (8.25 units)	$629.50	M			
03/21/01		$1,237.50 (8.25 units)	$610.75	M			
03/22/01		$1,200.00 (8.0 units)	$592.00	M			
03/23/01		$1,200.00 (7.0 units)	$592.00	M			
03/26/01		$1,200.00 (7.0 units)	$592.00	M			
03/27/01		$1,200.00 (7.0 units)	$592.00	M			
03/28/01		$1,237.50 (8.25 units)	$610.50	M			
03/29/01		$1,200.00 (7.0 units)	$592.00	M			
03/30/01		$1,275.00 (8.5 units)	$629.00	M			
04/03/01		$75.00 (.5 units)	$0.00	F			
04/04/01		$1,237.50 (7.0 units)	$610.50	M			
04/05/01		$1,275.00 (8.5 units)	$629.00	M			
04/06/01		$1,275.00 (8.5 units)	$629.00	M			
04/09/01		$1,200.00 (7.0 units)	$592.00	M			
04/10/01		$1,312.50 (8.75 units)	$647.50	M			
04/11/01		$1,237.50 (7.0 units)	$610.50	M		TWCC Rule 134.600 (h)	
04/12/01		$1,162.50 (7.0 units)	$573.50	M			
04/13/01		$1,162.50 (7.75 units)	$573.50	M			
04/16/01		$1,237.50 (8.25 units)	$610.50	M			
04/17/01		$75.00 (0.5 unit)	$0.00	A		MFG MGR (I)(G) CPT descriptor	
05/02/01		$1,237.00 (7 units)	$610.50	M			
05/03/01		1,162.50 (7.0 units)	$536.50	M			
05/04/01		$1,237.50 (8.25 units)	$610.50	M			
05/07/01		$1,050.00 (7 units)	$518.00	M			
05/08/01		$1,275.00 (8.5 units)	$629.00	M			
05/09/01		$1,087.50 (7.25 units)	$573.50	M			
05/10/01		$1,275.00 (8.5 units)	$629.00	M			
05/11/01		$1,162.50 (7.75 units)	$536.50	M			
05/14/01		$1,087.50 (7.25 units)	$536.50	M			
05/15/01		$1,237.50 (8.25 units)	$592.00	M			
Totals		$35,100.00	$17,224.25				The Requestor **is** entitled to additional reimbursement in the amount of **$75.00** for the date of service 04/03/01.

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $75.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 23rd day of July 2002.

Michael Bucklin, LVN
Medical Dispute Resolution Officer
Medical Review Division

MB/mb

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.